HIV AND HEPATITIS C IN PRISON

In Canada and elsewhere, prisons have become breeding grounds for HIV and the hepatitis C virus (HCV). A Vancouver study estimated that incarceration more than doubled the risk of HIV infection for people who use illegal drugs, and estimated that 21 percent of all HIV infections among people who inject drugs in Vancouver may have been acquired in prison. A 2010 survey by the Correctional Service of Canada (CSC) reported rates of HIV and HCV in federal prisons to be 15 and 39 times, respectively, the estimated prevalence in the Canadian population.

The sharing of used needles to inject drugs is a principal factor contributing to the high rates of infection in prisons. Because of the scarcity of needles and syringes in prison, people who inject drugs there are more likely to share injecting equipment than people in the outside community, thereby compounding their risk.

Needle and syringe programs (NSPs) are an important way to reduce the risk of infection from sharing used injecting equipment. In 2001, over 200 NSPs were serving Canadian communities, with more planned, and these programs have been supported by all levels of government. Many evaluations of NSPs have demonstrated that they reduce the risk of HIV and HCV, are cost-effective, and facilitate access to care, treatment and support services.

Prison-based needle and syringe programs (PNSPs) offer similar benefits, but for a population even more at risk. As of 2011, and in response to this known risk, PNSPs have been introduced in more than 60 prisons of varying sizes and security levels in Switzerland, Germany, Spain, Luxembourg, Moldova, Belarus, Kyrgyzstan, Armenia, Romania and Iran.

No matter the context studied, evaluations of PNSPs — including in 2006 by the Public Health Agency of Canada (PHAC) at CSC’s request — have consistently demonstrated that they:

- reduce needle-sharing;
- do not lead to increased drug use or injecting;
- reduce drug overdoses;
- facilitate referrals of users to drug treatment programmes;
- have not resulted in needles or syringes being used as weapons against staff or other people in prison;
- have been effective in a wide range of institutions; and
- have effectively employed different methods of needle distribution, such as peer distribution by people in prison, hand-to-hand distribution by prison health-care staff or outside agencies, and automatic dispensing machines.

Yet in spite of the overwhelming evidence of these benefits, Canadian prisoners continue to be denied access to sterile injecting equipment. This harms the health of people in prison, given the increasing prevalence of HIV and HCV behind bars, as well as correctional staff who run the risk of being exposed to non-sterile needles. Denying prisoners access to PNSPs also poses broader public health risks, since the vast majority of people who spend time in prison return to their families and communities — with whatever health problems they may have acquired while serving time.
Between 2000 and 2002, the number of federal prisoners living with HIV and/or HCV being released into the community increased 60 percent and 13 percent respectively. With skyrocketing rates of HIV and HCV in prison, society also bears the cost of treatment for those who are infected; according to CSC, treating a person in prison with HCV costs an estimated $22,000 and treating a person in prison with HIV costs $29,000 per year. It is far more cost-effective to provide prisoners with sterile injecting equipment than to treat their HIV or HCV infection.

Specific factors contribute to the HIV and HCV epidemic behind bars:

- **Conflict with the law and incarceration are often a result of offences arising from the criminalization of certain drugs, related to supporting drug use, or to behaviours brought about by drug use.** In 2002, more than half a million criminal charges filed in Canada were attributed to illicit drugs. In Canadian federal prisons, 30 percent of women and 14 percent of men have been incarcerated on drug-related charges.

- **Many people assume that in a highly restricted, secured environment such as a prison, drug use would be rare. But despite their illegality, the penalties for their use, and the considerable resources spent by prison systems to control their availability, illegal drugs do get into prisons and people use them — a reality recognized by prison systems themselves.** Drug-use patterns between persons who inject drugs in prison and those who are not in prison are strikingly similar.

- **In a 2010 survey by CSC, 34 percent of men and 25 percent of women in federal prisons admitted using drugs in the past six months in prison, and 17 percent of men and 14 percent of women admitted injecting drugs.** Numerous international studies have also confirmed the prevalence of injection drug use in prisons worldwide.

- **According to the Public Health Agency of Canada (PHAC), two thirds of people incarcerated in federal prisons have substance-use problems, of which 20 percent require treatment.** In particular, women and Aboriginal people suffering addiction are disproportionately represented in prison.

- **Many people suffering from addiction also suffer from mental health issues.** In 2007, CSC reported that 12 percent of men and 26 percent of women in federal prisons had been identified with “very serious mental health problems,” 15 percent of men and 29 percent of women in federal prisons had previously been hospitalized for “psychiatric reasons,” and the percentage of federal prisoners prescribed medication for “psychiatric concerns” at admission had more than doubled from 10 percent in 1997–1998 to 21 percent in 2006–2007.

- **Although people who inject drugs may inject less frequently in prison, the scarcity of sterile injecting equipment and the punishments meted out for drug use mean more people in prison resort to sharing used needles.** Among the prisoners who reported having injected drugs in prison in the 2010 CSC study, 55 percent of men and 41 percent of women used someone else’s used needle, and 38 percent of men and 29 percent of women shared a needle with someone who has HIV, HCV, or an unknown infection status.

- **A number of prison systems in Canada have responded to the problem of HIV and HCV transmission in prison by making bleach available.** Bleaching used injecting equipment is an important second-line strategy in the absence of access to sterile needles and syringes, but numerous studies have demonstrated that using bleach to clean injecting equipment is not fully effective in reducing HCV transmission and that disinfection with bleach appeared to offer no, or at best little, protection against HIV infection, for reasons such as incorrect or ineffective application.

**RIGHTS AND REASON: THE WAY FORWARD**

In spite of compelling evidence of the public health benefits of PNSPs and growing community support for such programs, the Canadian government has chosen to focus primarily — and ineffectively — on drug prohibition. Not only does this harm the health of people in prison and public health more broadly, but it is also a violation of prisoners’ human rights. The pressing need for safe access to sterile injecting equipment within Canadian prisons must be met to ensure that the rights enshrined in Canadian and international law are not abstract values, but tangible rights to be enjoyed by all — and for the protection of all.
Everyone is entitled to human rights, and people do not surrender those rights when they enter prison. Rather, people in prison are supposed to retain all human rights that are not necessarily removed as a consequence of their imprisonment.27 This includes:

- the right to the “highest attainable standard of health”28
- the right to life29
- the right to liberty and security of the person30
- the right to equality31
- the right not to be subjected to cruel and unusual treatment or punishment32
- access to a standard of health care that is equivalent to that available in the community33

Prisoners who inject drugs experience violations of those rights, particularly in cases where individuals suffer from addiction, are compelled to go to dangerous lengths to inject, or have been infected with HIV and/or HCV in prison because they were denied access to sterile injection equipment that would have been available to them from a needle and syringe program on the outside. Governments in Canada have a legal obligation to act to protect and promote health, including that of people in prison — and this includes taking measures to prevent the spread of contagious diseases in prison.34

**FACTS AND FIGURES**

- **Federal prisoners** — many of whom inject drugs and/or suffer from addiction — **have higher rates of HIV and HCV than the general public.** Rates of HIV and HCV are, respectively, 15 and 39 times greater than in the Canadian adult population as a whole.
- **PNSPs work.** There is international evidence that PNSPs reduce the risks of HIV and HCV infection that result from injection drug use in prison and have not resulted in increased institutional violence.
- **People in our communities currently have access to needle and syringe programs.** Therefore, people in prison should have the same access to sterile injecting equipment. It **violates the human rights of people in prison to deny them the same tools available to people in our communities,** who use these programs to protect themselves from disease.
- **Investing in the prevention of blood-borne diseases in prisons saves taxpayer dollars.** CSC has estimated the annual cost of providing HIV treatment for a prisoner at $29,000, and for HCV treatment at $26,000.35
- **In Canada, PNSPs have been called for by bodies ranging from CSC’s own Expert Committee on AIDS and Prisons and the Correctional Investigator of Canada, to the Canadian Medical Association, the Ontario Medical Association and the Canadian Human Rights Commission.** PHAC has also affirmed many of the positive findings regarding PNSPs in a 2006 study.41 Worldwide, numerous international organizations including the World Health Organization, UNAIDS and the UN High Commissioner on Human Rights have called for governments to provide sterile injecting equipment to people in prison as a matter of sound public-health policy and human rights.42

**CASE STUDY: Prison-based needle and syringe programs in Moldova**

Over a decade ago, Moldova’s prison authorities acknowledged that it was impossible to prevent illegal drugs from entering prisons, and that pretending that drug use wasn’t occurring would only increase the spread of HIV and hepatitis C virus.

Since 1999, local non-governmental organizations have provided prisoners with HIV/AIDS education and a wide range of harm reduction services, including sterile injecting equipment. The experience has been overwhelmingly positive: drug use has not increased in prisons, available data suggests a reduction in HIV and hepatitis C incidence, and needles have never been used as weapons against prison staff or fellow prisoners.
Importantly, sterile injecting equipment is distributed by prisoners who have been trained as outreach volunteers to provide services to fellow prisoners. This ensures users’ confidentiality and that materials are accessible 24 hours a day, seven days a week. And health and human rights are being safeguarded in the process.


ENDNOTES

5. See, for example, studies cited in footnotes 53–56 of S. Chu and R. Elliott, *Clean Switch* (supra).
7. See, for example, studies cited in footnote 60 of S. Chu and R. Elliott, *Clean Switch* (supra).
9. See, for example, studies cited in footnote 6 of S. Chu and R. Elliott, *Clean Switch* (supra).
10. See, for example, organizations discussed on p. 10 of *Prison Needle Exchange* (supra).
12. See, for example, studies cited in footnote 22 of S. Chu and R. Elliott, *Clean Switch* (supra).
15. See, for example, studies cited in footnotes 38–44 of S. Chu and R. Elliott, *Clean Switch* (supra).
18. See Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights*, 16 Dec 1966, 993 U.N.T.S. 3 (entered into force 3 January 1976), Section 86 of the CCRA also mandates CSC to provide every person in prison with “essential health care” that will contribute to his or her rehabilitation and reintegration into the community.
20. See Article 9 of the ICCPR and s. 7 of the Charter.
21. See Article 26 of the ICCPR and s. 15 of the Charter.
22. See Article 7 of the ICCPR and s. 12 of the Charter.
32. See, for example, organizations discussed on p. 10 of S. Chu and R. Elliott, *Clean Switch* (supra).